

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					83 08490 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Edith D Adkins			2a. DATE OF DEATH MONTH DAY YEAR Mar 18 43			2b. HOUR 3 25 PM			
3. SEX female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 13, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
12. CITY OR TOWN OF DEATH Easton		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN Talbot		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 13 N. Aurora St. 21601			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM HUGHLETT ADKINS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY DAWSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-22-5494		17. INFORMANT ADDRESS William H. Adkins, 11 Easton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>2252</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Phlebotomy - (L) lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>17 Mar</u> 19 <u>83</u> to <u>18 Mar</u> 19 <u>83</u> , that (1) <u>was</u> lost saw the deceased alive on <u>17 Mar</u> 19 <u>83</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>was</u> (did not) view the body after death.									
22b. SIGNATURE <u>Thurston Harrison</u> <u>Dawson</u>				DEGREE <u>MD.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>18 Mar 83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thurston Harrison, M.D.				22e. ADDRESS Dutchman's Lane Easton, Md. 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-18-1983		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Lewes, Sussex, Delaware			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR MAR 24 1983			

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FORWARDED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DMHM - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08491	
1. FOR STATE REGISTRAR 4-21-83 en										3	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hubert Baldwin										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 19	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 3 7 12		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3-30-83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLORIDA				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TATBOT MD	
10. CITY OR TOWN OF DEATH Easton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital at Easton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY RET.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md		13b. COUNTY DOR		13c. CITY OR TOWN E.N. MARKET		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. Box 39 E. New Market MD 21631			
14. FATHER'S NAME FIRST MIDDLE LAST ELIJAH BALDWIN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY WHEATLEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS MARY WHEATLEY E. NEW MKT MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 0119 IMMEDIATE CAUSE (a) Chronic Debility DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Old inactive Pulmonary Tuberculosis											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Louis A. Welty				TITLE (SPECIFY) M.D. MD				DATE SIGNED 3-31-83			
EXAMINER'S NAME (TYPE OR PRINT) Louis S. Welty				ADDRESS Easton Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 4-12-83		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON		23d. LOCATION CITY OR TOWN COUNTY STATE Hubert Dor. Md.			
24. FUNERAL DIRECTOR NAME Frederick C. Blair				ADDRESS ST. CLAIR F. HOME CAMBRIDGE, MS.		25a. DATE OF REGISTRATION APR 19 1983		25b. REGISTRAR'S SIGNATURE John J. Canine			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 0 8 4 9 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Lillian VIRGINIA Bergling				2a. DATE OF DEATH MONTH DAY YEAR 3-31-83		2b. HOUR 9¹⁰ PM	
3. SEX female		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 2-18-87		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY none	
13a. STATE Md. 13b. COUNTY Montgomery 13c. CITY OR TOWN Kensington				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5103 Flanders Ave. 20895	
14. FATHER'S NAME FIRST MIDDLE LAST James C. Loveless				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Hook			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 579-14-2542		17. INFORMANT SON ADDRESS SAME AS 13 Joseph Bergling Kensington, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Cardiac Arrest Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF Atherosclerosis years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3-26-83 3-31-83			
22a. I certify that (I) (this hospital) attended the deceased from 3-31-83 to 3-31-83 , that (I) (we) last saw the deceased alive on 3-31-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas W. Fauntleroy, M.D.				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-1-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas W. Fauntleroy, M.D.				22e. ADDRESS S. Washinton St. Easton, MD 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/4/83		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME John E. Boulis ADDRESS Greensboro				25a. DATE REC'D BY REGISTRAR APR 8 1983		25b. REGISTRAR'S SIGNATURE John E. Boulis	

BP _____

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3-31-39

Berling

Lillian

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2-18-37

Can.

Female

Toll

x

U.S.A.

Mr.

none

Domestic

Memorial Hospital

Birth

7107 Standers Ave.

x

Montgomery Kennistown

Mr.

Elizabeth Hook

James C. Lovelace

Kennistown, Md.

578-14-2542 Joseph Berling

no

Kennistown

Washington, D.C.

Mr. Oliver

Bureau



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 3 0 8 4 9 3		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Ellen		Ursula		Birmingham				3-3-83		8:30 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
female		white		9 8 1891		91					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Indianapolis		U.S.				Talbot County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Easton		Home for Aged Women Easton		Housewife							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		13f. ZIP CODE	
Md.		Talbot		St. Michael				219 R. Ave.		21663	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
James F Hennsey		Rose Stapleton									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		352-03-5433		Elaine K. McWhorter		Easton, Md.					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMONIA</u>										8 DAYS	
4860											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>ADVANCED DEMENTIA</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1975, 19, to 3/3/83, 19, that (I) (we) last saw the deceased alive on 3/3/83, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
C. R. W. Bain		MD				3/4/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
C. R. W. Bain		Easton, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation		3-4-83		Delmarva Crematory		Lewes Sussex Del.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Newnam Funeral Home		Easton, Md.		MAR 8 1983		John A. Carver					



RECEIVED

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 3 0 8 4 9 4					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carl Otto Brauchle, Sr.				MARCH 1 1983				12:05 ^a M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR NOV. 7 1894		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH Trappe		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6 Greenfield Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY Caroline		13c. CITY OR TOWN Federsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Brauchle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Hahn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO WW I 214-36-5563		17. INFORMANT ADDRESS Helen B. Asmussen Trappe, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease Years DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Pyelonephritis and Obstructive Uropathy									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE P. Gregg Rhodes				DEGREE M.D.				22c. DATE SIGNED 3/4/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Gregg Rhodes, M.D.				22e. ADDRESS Easton, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-4-83		23c. NAME OF CEMETERY OR CREMATORY Jr. Order Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Preston Caroline Md			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR (SEE INSTRUCTIONS) REGISTRAR'S SIGNATURE MAR 8 1983 John J. Caruth			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE						8 3 0 8 4 9 5	
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) William A BROWN				2a. DATE OF DEATH MONTH DAY YEAR March 3 1983		2b. HOUR 1:25 PM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 1 14		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman		12b. KIND OF BUSINESS OR INDUSTRY + Tent	
13a. STATE MD		13b. COUNTY GA		13c. CITY OR TOWN Gosville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Armon R Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Heath		13e. STREET ADDRESS Route 1 Box 245		21638	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. —		17. INFORMANT Beulah Gould		ADDRESS Gould	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2898 IMMEDIATE CAUSE (a) Bone Marrow Failure							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs
DUE TO, OR AS A CONSEQUENCE OF (b) myelofibrosis							5 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/2 1983, to 3/3 1983, that (I) (we) lost saw the deceased alive on 3/2 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) William J. Brundage				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
23a. BURIAL/CREMATION/REMOVAL SPECIAL		23b. DATE 3/2/83		23c. NAME OF CEMETERY OR CREMATORY Robinson Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD MD	
24. FUNERAL DIRECTOR NAME Harold W. Doshoff				ADDRESS Easton MD		25a. DATE REC'D. BY REGISTRAR MAR 11 1983	
				25b. REGISTRAR'S SIGNATURE John J. Conish			

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELLEN DEBORAH BLOM PHIPPS BURGER			2a. DATE OF DEATH MONTH DAY YEAR MARCH 30, 1983			2b. HOUR 7:52A.M.				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV. 14, 1887		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SWEDEN		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.				
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL AT EASTON				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. PRAC. NURSE -		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DELAWARE			13b. COUNTY SUSSEX		13c. CITY OR TOWN OCEANVIEW		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS BOX 64 99999	
14. FATHER'S NAME FIRST MIDDLE LAST PEIR			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA BLOM							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 483-03-5230		17. INFORMANT ADDRESS MILLIE OSTERGARD, OCEAN VIEW, DEL.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIAC DECOMPENSATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>ACUTE SEVERE FX LEFT HIP</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>3-22</u> , 19 <u>83</u> , to <u>3-30</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>3-30</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>R.B. Sanchez</u>						DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R.B. Sanchez</u>						22e. ADDRESS <u>322 COMMERCE DR. EASTON, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 4/1/83		23c. NAME OF CEMETERY OR CREMATORY PRESBYTERIAN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE OCEAN VIEW, SUSSEX, DEL.			
24. FUNERAL DIRECTOR <u>A.D. MELSON</u>						25. DATE REC'D. BY REGISTRAR APR 5 1983		25. REGISTRAR'S SIGNATURE <u>John J. Connel</u>		

STATION 3



14-10-1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed under the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 3 0 8 4 9 7				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			2b. HOUR	
Norris L. Chambers					3-9-83			1 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		Caucasian		APRIL 23 1905		77		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				TALBOT MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Easton		Memorial Hospital				Mechanic		Trucking	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
Md.		Talbot		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		413 North St. 21601			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Isaac Jerome Chambers					Annie Rebecca Todd				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					213-24-2592		Carolyn O. Chambers Easton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Refractory congestive heart failure									
4140 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) Anterior-cerebral artery disease									Uncertain
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
None									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			HOUR A.M. MONTH DAY YEAR						
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (in) (this hospital) attended the deceased from 10-30, 1982, to 3-9, 1983, that (he) (she) last saw the deceased alive on 3-9, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
Robert W. Trever, M.D.					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			3-9-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Robert W. Trever, M.D.					RD 3 Box 297 Easton, Md. 21601				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial			3-12-83		Jr. Order Cem.		Preston		
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REG. OFF.		25b. SIGNATURE		
NAME ADDRESS					MAR 11 1983		Carolyn O. Chambers		
Newnam Funeral Home					Easton, Md.				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BERTHA N. CLARK			2a. DATE OF DEATH MONTH DAY YEAR 3-24-83		2b. HOUR 10 AM
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Sept. 2, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) factory worker	12b. KIND OF BUSINESS OR INDUSTRY defence
13a. STATE Md.		13b. COUNTY Q.A. Co.	13c. CITY OR TOWN Stevensville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Hopper Lewis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosie Ireland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-20-5047		17. INFORMANT ADDRESS 21666 Md. Mrs. Elain Gardner, P.O. Box #43, Stevensville	
18. CAUSE OF DEATH (Enter only one cause per line for each line and, if possible, state the immediate cause.) Arteriosclerotic Heart Disease 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Osteomyelitis. Non-union left ulna/diaphysis fx					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 23 , 19 83 , to Mar 24 , 19 83 , that (I) (we) last saw the deceased alive on Mar 23 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard F. Manegold		DEGREE MD		22c. DATE SIGNED 3/25/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Manegold, M.D.		22e. ADDRESS 115 Bay Street, Easton, MD 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-27-83		23c. NAME OF CEMETERY OR CREMATORY Stevensville Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Stevensville Q.A. Co. Md.		23e. DATE REC'D. BY REGISTRAR MAR 30 1983			
24. FUNERAL DIRECTOR NAME Funeral Home P.A. Helfenbein-Hubbard		ADDRESS 21619 Chester, Md.		25. REGISTRAR'S SIGNATURE John D. [Signature]	

BP

RECEIVED
FEB 15 1964
U.S. AIR FORCE



TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[illegible text follows]

[illegible text follows]

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]
6. [illegible]
7. [illegible]
8. [illegible]
9. [illegible]
10. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 0 8 4 9 9

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELSIE Mae Cohey			2a. DATE OF DEATH MONTH DAY YEAR 3 15 83			2b. HOUR 4:40 PM			
3. SEX female		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 7-2-1924		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT County Md.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EASTON MEMORIAL Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Sea Food Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Md. Caroline Ridgely			13c. CITY OR TOWN Ridgely		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Crouse Mill Rd. 21660		
14. FATHER'S NAME FIRST MIDDLE LAST Reverdy Quillen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olive Skinner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-14-4058		17. INFORMANT Norman Layton, Sr.			ADDRESS Ridgely, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 Myocardial Infarction IMMEDIATE CAUSE (a) ABCD DUE TO, OR AS A CONSEQUENCE OF (b) ABCD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ABCD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 d									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COPD Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT HOME		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 4/3/83 to 3/15/83 , that (2) (we) last saw the deceased alive on 4/3/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I have) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/15/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Name]				22e. ADDRESS [Address]					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-19-83		23c. NAME OF CEMETERY OR CREMATORY Greensboro Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Greensboro Cal. Md.			
24. FUNERAL DIRECTOR [Signature]				ADDRESS Greensboro, Md.		25. REGISTERED BY [Signature]			

BP

3-19-83

Bureau

Greenboro Cemetery, Greenboro, N.C.

Greenboro, N.C.

2029 CO-1

RECEIVED

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Reverdy Outlin

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Ms.

Caroline Ridgely

x

Grouse Hill Rd.

Ms.

U.S.A.

x

Gov.

7-2-1951

28

Female

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Clifford L Coleman		MONTH DAY YEAR 3 20 83		9 23 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	Caucasian	MONTH DAY YEAR APR. 28 1916	66 YRS.	IF UNDER 24 MRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Delaware	U.S.A.		TALBOT MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
EASTON	MEMORIAL HOSPITAL		Architect		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Talbot	Oxford	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	228 S. Morris St. 21654	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Harry Coleman		FIRST MIDDLE LAST Idella Stewart			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
Yes		WW II	P.O. Box 325 Oxford, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anterior Ischemic Heart Disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3-14-83</u> <u>3-14-83</u> <u>Uncertain</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Pre-leukemia</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <u>3-14</u> , 19 <u>83</u> , to <u>3-20</u> , 19 <u>83</u> , that (1) (two) lost saw the deceased alive on <u>3-20</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (two) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Robert W. Trever, M.D.				3-21-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Robert W. Trever, M.D.		RD3 Box 297 Easton, Md. 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Cremation	3-21-83	Delmarva Crematory	Lewes Sussex Del.		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS Newnam Funeral Home Easton, Md.		MAR 24 1983		[Signature]	

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-355-1222.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 3 0 8 5 0 1	
1. FOR STATE REGISTRAR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Otho Byron COURSEY					3 16 83 945 M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)
Male		White		April 4, 1906		76 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland		USA				TALBOT MD.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
EASTON		MEMORIAL HOSPITAL				Deck Hand (ret.)
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		12b. KIND OF BUSINESS OR
Maryland		Queen Anne's		Grasonville		US Army Corps of Engineers
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Charles Byron Coursey			Sadie Freburger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes			WW II		R.D. #1, Box 132	
			212-16-1060		Mrs. Virginia Clough, Grasonville, Md. 21638	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) ACUTE RENAL FAILURE						4 DAYS
4476						
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE VASCULITIS						10 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a						
BONE METASTASES UNKNOWN SOURCE.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
		P.M. 19				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3/14/93, 19, to 3/16/93, 19, that (I) (we) lost						
saw the deceased alive on 3/16/93, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE C. R. W. Barton				DEGREE MD		22c. DATE SIGNED 3/16/93
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. R. W. Barton				22e. ADDRESS Easton, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 19, 1983		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Easton, Talbot, Md.
24. FUNERAL DIRECTOR NAME James H. Barton, Jr. ADDRESS 21617 Barton Funeral Home Centreville, Md.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 24 1983 John J. Canine		

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 0 8 5 0 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lanet N. Curtis			2a. DATE OF DEATH MONTH DAY YEAR 3-1-1983			2b. HOUR 3:04 P			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR JULY 18 1895		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital at Easton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 501 E. Dutchman's Lane		
13a. STATE Md.		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		21601			
14. FATHER'S NAME FIRST MIDDLE LAST Arthur H. Nevius				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie Hulst					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-50-1907		17. INFORMANT ADDRESS Nevius M. Curtis Wilmington, Del.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7/9 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 3/1/83					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE ST. MICHAELS MD 21663					
22a. I certify that (1) (this hospital) attended the deceased from 3/1/83 19 3/1/83 19, to 3/1/83 19, that (1) (we) lost 7/9 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W. S. Bremer				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/2/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm S BREMER				22e. ADDRESS ST. MICHAELS MD 21663					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-3-83		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Del			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR MAR 8 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

BP



Target

Eastern General Hospital of Boston

2nd Floor

Ward 10



11/23

11/23

11/23

11/23

Ward 10

Ward 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					8 3 0 8 5 0 3				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Rebecca R. Daffin					3-1-83				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
Female		Caucasian		FEB. 1 1910		73		6:36 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Talbot MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Easton		Memorial Hospital				Housewife			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS			
Md.		Talbot		Easton		R.D. 1, Box 327 21601			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
William D. Roe					Nettie J. Marshall				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					218-20-400		Robert J. Daffin Easton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years									
PART 2. (OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.) DIABETES MELLITUS									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 80, to 3/1, 19 83, that (I) (we) lost saw the deceased alive on 2/22, 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE William J. Banfield MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
William J. Banfield, M.D.					Easton, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			3-4-83		Spring Hill		Easton Talbot Md		
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Newnam Funeral Home Easton, Md.					MAR 8 1983		John J. Conner		

MEDICAL CERTIFICATION

29

3-1-83

Ted T

Memorial Hospital

2012



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #5&6 Film G578 4/11/83 rc		STATE OF MARYLAND	
1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
CERTIFICATE OF DEATH		REG. NO. 83 08504	
1 DECEASED NAME (TYPE OR PRINT) HARRIETT DEFREHN		2a. DATE OF DEATH MONTH DAY YEAR 3/ 28 / 83	
3 SEX Female		4 RACE Caucasian	
5 DATE OF BIRTH 1901 MONTH DAY YEAR AUG. 7 1905		6. AGE (IN YEARS LAST BIRTHDAY) 77 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE PINES	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE N.J.		13b. COUNTY Bergen	
13c. CITY OR TOWN Saddle River		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST (unknown) MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE LAST Fisher	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 233-01-8119D	
17 INFORMANT Box 133 Rt. 1, Pea Neck Rd. St. Michaels, Md.		17a. STREET ADDRESS 117 E. Saddle River Rd.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Lymphatic Leukemia 2041 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Anemia			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Dec 28 19 81 to March 28 19 83, that (I) (we) saw the deceased alive on March 1 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Richard F. Manegold MD		22c. DATE SIGNED 3/29/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard F. Manegold, M.D.		22e. ADDRESS 115 Bay St. Easton, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-31-83	
23c. NAME OF CEMETERY OR CREMATORY West Pittston Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE W. Pittston Luzerne PA.	
24 FUNERAL DIRECTOR NAME Newnam Funeral Home		25a. DATE REC'D. BY REGISTRAR 4 APR 1983	



APR 4 1983
Frank J. Gault

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8308505							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORMAN M EDWARDS					2a. DATE OF DEATH MONTH DAY YEAR 3 4 83			2b. HOUR 10⁵⁰ PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1/ 5 1893		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farm	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Greensboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Sunset Avenue 21639	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Edwards				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Greenlee					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217-03-5993		17. INFORMANT ADDRESS Robert Edwards Goldsboro, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral lower lobe pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) COPD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ASCD & Ventricular failure									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. — 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE — 83 — 3/4 83					
22a. I certify that (I) (this hospital) attended the deceased from 3/4 83 to 3/4 83 , that (I) (we) last saw the deceased alive on 3/4 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Albert T. Dawkins Jr.				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/5/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT T. DAWKINS JR. MD				22e. ADDRESS ROUTE 3, Box 127 EASTON MARYLAND 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/8/83		23c. NAME OF CEMETERY OR CREMATORY Greensboro Cemetery Greensboro CA		23d. LOCATION CITY OR TOWN COUNTY STATE MD			
24. FUNERAL DIRECTOR NAME John E. Boulos				ADDRESS Greensboro		25a. DATE REC'D. BY REGISTRAR MAR 14 1983		25b. REGISTRAR'S SIGNATURE John E. Boulos	

BP

Robert Edwards Goldsboro, MD

217-03-5993 Robert Edwards Goldsboro, MD

Joseph Edwards Greenboro

Caroline Greenboro

Edison

White

217-03-5993 Robert Edwards Goldsboro, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 0 8 5 0 6 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Fannie Dryden Funk				2a. DATE OF DEATH MONTH DAY YEAR MARCH 31 1983				2b. HOUR 4:00 P.M.			
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR OCT. 27 1910		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.					
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 5 Box 410 Doncaster				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 5, Box 410 21601	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Dryden				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Taylor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 084-38-9884		17. INFORMANT ADDRESS Marion F. Hustoun Washington, D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 DUE TO, OR AS A CONSEQUENCE OF Carcinoma of Breast (b) DUE TO, OR AS A CONSEQUENCE OF Carcinoma of Breast (c) DUE TO, OR AS A CONSEQUENCE OF Carcinoma of Breast APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Nov 81											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from July 23 1983 to March 31 1983, that (1) we last saw the deceased alive on March 30 1983, and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death.											
22b. SIGNATURE R. Lane Wroth, M.D.				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-1-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Lane Wroth, M.D.				22e. ADDRESS St. Michaels, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-2-83		23c. NAME OF CEMETERY OR CREMATORY Funk's Grove Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Shirley McLean Ill.					
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR APR 4 1983		25b. REGISTRAR'S SIGNATURE John J. Conner			

BP



Robert Lawrence Brown, Jr.
19-14

Robert Lawrence Brown, Jr.
19-14

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

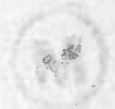
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mattie L. Grooms			2a. DATE OF DEATH KNOWN OF ESTI- MATED MONTH DAY YEAR 3 12 19 83			2b. HOUR a. M 8:40	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 3 5 40	6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 12 19 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot County, MD.	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN EASTON		13d. INSIDE (CITY LIMITS?) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE JONES		13e. STREET ADDRESS RFD GREENSBORO ROAD 21601			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS ALICE DOWELL CHARLOTTEVILLE, VIRGINIA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke & Soot Inhalation 8902 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:45 AM 3 12 19 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject involved in trailer fire			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE RFD Greensboro Rd., Talbot County, Maryland			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT) E.L. PHILLIPS		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 3-13-83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		23b. DATE 3-16-83		23c. NAME OF CEMETERY OR CREMATORY GROOMS FAMILY CEMTERY		23d. LOCATION CITY OR TOWN COUNTY STATE LOUISA COUNTY VIRGINIA	
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS 1721 N. MONROE ST.				25a. DATE REC'D. BY REGISTRAR MAR 16 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535



RECEIVED

NOV 19 1964

NOV 19 1964



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE THE CERTIFICATE. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roy E. Grooms						2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 3 12 19 83			2b. HOUR M 9:00			
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 3 25 52	6. AGE (IN YEARS) LAST BIRTHDAY 30 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 3 12 19 83			2d. HOUR a. M 9:00			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? us		8. MARRIED XX NEVER MARRIED WIDOWED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot County, MD.						
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RFD Greensboro Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. CITY OR TOWN TALBOT		13c. CITY OR TOWN EASTON		13d. INSIDE CITY LIMITS? YES NO X		13e. STREET ADDRESS RFD GREENSBORO ROAD 21601				
14. FATHER'S NAME FIRST MIDDLE LAST JOHN E. GROOMS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS MARY GROOMS PALMYRA, VIRGINIA						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke & Soot Inhalation 8902 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES NO XX				
21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:45xx 3 12 19 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject involved in trailer fire						
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK XX				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21i. LOCATION STREET CITY OR TOWN COUNTY STATE RFD Greensboro Rd., Talbot County, Maryland						
22a. I certify that I took charge of the remains described above, held on Autopsy, Inspection XX, Inquiry, and in my opinion death resulted from: Natural causes Accident XX Suicide Homicide Undetermined manner												
ACTUAL SIGNATURE [Signature] EXAMINER'S NAME (TYPE OR PRINT) E.L. PHILLIPS						TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 3-13-83		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL				23b. DATE 3-16-83		23c. NAME OF CEMETERY OR CREMATORY GROOMS FAMILY CEMTERY			23d. LOCATION CITY OR TOWN COUNTY STATE LOUISA COUNTY VIRGINIA			
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS						1721 N. MONROE ST.		25a. DATE REC'D. BY REGISTRAR MAR 16 1983		25b. REGISTRAR'S SIGNATURE [Signature]		



COLLECTOR'S LABEL
KIMWOOD

Handwritten signature or text at the bottom left.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH														REG. NO. 08509	
1. DECEASED NAME (TYPE OR PRINT) Travis E. Grooms										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 3 DAY 12 YEAR 1983		2b. HOUR 8:40 A.M.			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 7 DAY 23 YEAR 79		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 3		IF UNDER 1 YR. MONTHS 3 DAYS 12 HOURS 12 MIN.		2c. DATE PRONOUNCED DEAD MONTH 3 DAY 12 YEAR 1983		2d. HOUR 8:40 A.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA				7b. CITIZEN OF WHAT COUNTRY? US				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot County, MD.					
10. CITY OR TOWN OF DEATH Easton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND				13b. COUNTY TALBOT		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RFD GREENSBORO ROAD 21601					
14. FATHER'S NAME FIRST ROY MIDDLE GROOMS LAST GROOMS						15. MOTHER'S MAIDEN NAME FIRST MATTIE MIDDLE JONES LAST JONES									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MARY GROOMS PALMYRA, VIRGINIA							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke & Soot Inhalation Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 8902 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:45 PM 3 12 1983				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject involved in trailer fire							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET RFD Greensboro Rd., CITY OR TOWN Talbot County, COUNTY Maryland STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant MEDICAL EXAMINER						DATE SIGNED 3-13-83					
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL REMOVAL				23b. DATE 3-16-83		23c. NAME OF CEMETERY OR CREMATORY GROOMS FAMILY CEMTERY				23d. LOCATION CITY OR TOWN LOUISA COUNTY COUNTY VIRGINIA STATE					
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS ADDRESS 1721 N. MONROE ST.						25a. DATE REC'D. BY REGISTRAR MAR 16 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>							

MEDICAL CERTIFICATION

RECEIVED
JAN 1 1963



12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination made.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 3 0 8 5 1 0		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST LOLA HARRIS		2a. DATE OF DEATH MONTH DAY YEAR 3 - 20 - 83		2b. HOUR P 2:25 M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR FEB 16 1891		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE PINES		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Talbot		13c. CITY OR TOWN Oxford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Morris St. 21654	
14. FATHER'S NAME FIRST MIDDLE LAST J. Planner A. Elliott		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Kirby		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-38-1415		17. INFORMANT ADDRESS Royal Oak, Md. J. Franklin H. Brinsfield	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sepsis</u> 5698 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bowel Obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bowel Fistula</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>MO</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>ASPD</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 1/25 76		CITY OR TOWN 3/20 83		COUNTY 19 53	
22a. I certify that (I, (this hospital) attended the deceased from <u>3/20</u> 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I, (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Donald T. Lewers</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/24/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald T. Lewers, M.D.		22e. ADDRESS Easton, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-23-83		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cem.		23d. LOCATION CITY OR TOWN Easton		COUNTY Talbot	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR MAR 28 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captioned papers. Pages 1 and 2 should be filed with the Bureau of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	3	0	8	5	1	1	
1. FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) ROBERT H. HAWKINS										2a. DATE OF DEATH MONTH 3 DAY 8 YEAR 83				2b. HOUR 12:05^P			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH 8 DAY 25 YEAR 16		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Queen Anne		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TAIBOT MD.											
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE MD										13b. COUNTY QA		13c. CITY OR TOWN Centreville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rt. 1 Box 323 21617	
14. FATHER'S NAME FIRST William MIDDLE LAST Hawkins				15. MOTHER'S MAIDEN NAME FIRST ADA MIDDLE LAST Demby													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 216 14-9241		17. INFORMANT Lillian Hawkins				ADDRESS Rt. 1 Box 323 Centreville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) Carcinoma of Pancreas DUE TO, OR AS A CONSEQUENCE OF (b) year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) 																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR May 19 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from May 8 1983 to May 8 1983 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on May 8 1983 , and that in <input checked="" type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.																	
22b. SIGNATURE P. Gregg Rhodes				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/8/83									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. GREGG RHODES, M.D.				22e. ADDRESS 400 DUTCHMANS LANE, EASTON, MD 21601													
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL				23b. DATE 3/12/83		23c. NAME OF CEMETERY OR CREMATORY Chesterfield		23d. LOCATION CITY OR TOWN Centreville COUNTY QA STATE MD									
24. FUNERAL DIRECTOR NAME Eric P. Ashwell ADDRESS P.O. Box 606 EASTON, MD				25a. DATE REC'D. BY REGISTRAR MAR 14 1983		25b. REGISTRAR'S SIGNATURE John J. Carver											

BP

TSD/AT

MEMORANDUM FOR THE RECORD

IN P

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be signed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 3 0 8 5 1 2		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Edgar McPherson Howell			2a. DATE OF DEATH MONTH DAY YEAR MARCH 10, 1983		2b. HOUR 6:20p M		
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR JULY 16 1915		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH Oxford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 304 S. Morris Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Curator		12b. KIND OF BUSINESS OR INDUSTRY Mil. History	
13a. STATE Md.			13b. COUNTY Talbot		13c. CITY OR TOWN Oxford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST George Cook Howell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne McPherson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1940-1949 131-01-2452		17. INFORMANT ADDRESS Winifred H. Howell Oxford, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate</u> <u>1850</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-8</u> , 19 <u>82</u> to <u>10</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>3-8</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Stephen P. Carney</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-11-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.				22e. ADDRESS Easton, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-11-83		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Del.	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Md.		25a. DATE REC'D BY REGISTRAR MAR 15 1983	
25b. REGISTRAR'S SIGNATURE <u>John J. Carney</u>							

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

PLANT INDUSTRY

MAR 12 1983
J. L. G. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 3 0 8 5 1 3			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) CHARLES EDGAR HUTSON SR.				March 3, 1983			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 6, 1908		2b. HOUR 11: P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 74		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Bozman		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Box 252 Bozman, Md. 21612		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman			
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Bozman		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James H. Hutson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Z. Higdon		12b. KIND OF BUSINESS OR INDUSTRY Seafood			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 217-18-6226		17. INFORMANT ADDRESS Bozman, Md. Nancy R. Hutson Box 252 21612			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH month
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic Carcinoma							6 month
(c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Heart Disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE Richard F. Manegold				DEGREE		22c. DATE SIGNED 4/4/83	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Richard F. Manegold M.D.				22e. ADDRESS Easton, Maryland 21612			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE APRIL 4, 1983		23c. NAME OF CEMETERY OR CREMATORY Mary XX, Cemetery Bozman, Talbot Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR H. Wilson E. Bonard H. Michael, Jr.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John J. Conick	

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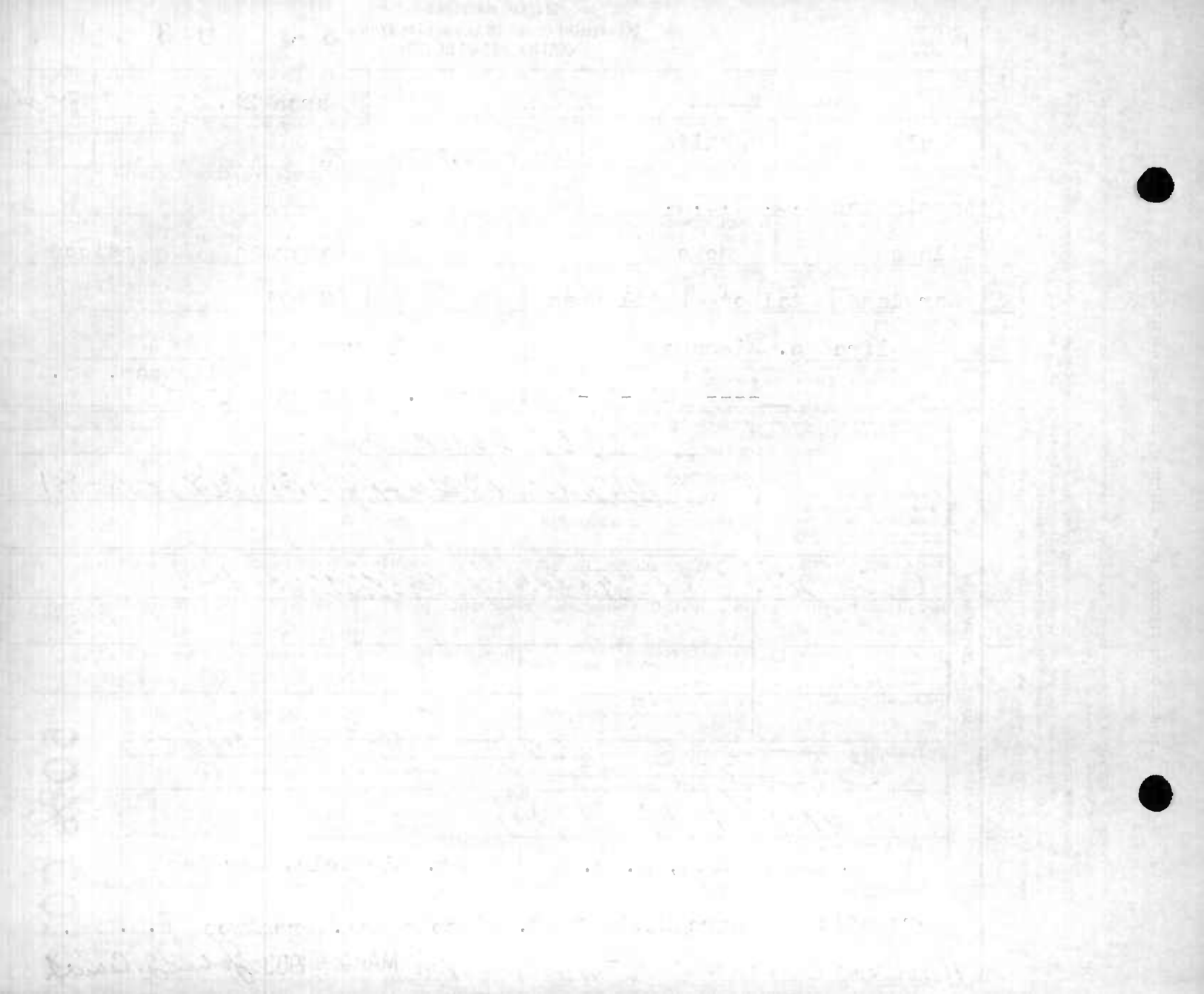
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR			REG. NO. 83 08514						
1. DECEASED NAME (TYPE OR PRINT) THOMAS ELMER KINNAMON			2a. DATE OF DEATH March 21, 1983			2b. HOUR 3:30 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 18, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10. CITY OR TOWN OF DEATH Tilghman		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman		12b. KIND OF BUSINESS OR INDUSTRY Seafood	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY talbot		13c. CITY OR TOWN tilghman		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21671	
14. FATHER'S NAME FIRST MIDDLE LAST Alfred G. Kinnamon					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Graves				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF NOT, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Tilghman, Md. Mary I. Kinnamon 21671					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 1850 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Prostate</u> June 81 (c) <u>Chronic Obstructive Pulmonary D.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
19. DATE OF OPERATION									
20a. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20b. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, MOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from <u>Feb 19 65</u> to <u>21 March 19 83</u> that (1) <u>was</u> lost saw the deceased alive on <u>3-19-83</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If we did <u>not</u> view the body after death.)									
22b. SIGNATURE <u>R. Lane Wroth</u> MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22c. DATE SIGNED 3-21-83									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. LANE WROTH, M. D.									
22e. ADDRESS St. Michaels, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation									
23b. DATE March 22, 1983									
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem. Brentwood P.G. Md.									
23d. LOCATION CITY OR TOWN COUNTY STATE									
24. FUNERAL DIRECTOR NAME ADDRESS <u>Harrison C. Leonard St Michaels, Md</u>									
25. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE MAR 24 1983 <u>Joan J. Connel</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND									
FOR STATE REGISTRAR 4-8-83 cn					DEPARTMENT OF HEALTH AND MENTAL HYGIENE				
CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
WILLIAM RAYMOND LAWRENCE					Mar. 27, 1983				
3. SEX					4. RACE				
male					caucasian				
5. DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)				
June 9, 1895					87 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?				
New York					U.S.				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				
Easton					Hill Manor Health Care Center				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
ship captain									
13a. STATE					13b. COUNTY				
Maryland					Talbot				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Gilbert F. Lawrence					Lillie Estelle Smith				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
					086-16-2527				
17. INFORMANT					ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c. PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (i) this hospital attended the deceased from 28 March 1983, to 27 March 1983, and that (ii) (a) the deceased died on 28 March 1983, and that (iii) (a) my opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE									
22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
22e. ADDRESS									
R. Lane Wroth, M.D.									
St. Michaels, Md. 21663									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)									
23b. DATE									
23c. NAME OF CEMETERY OR CREMATORY									
23d. LOCATION CITY OR TOWN COUNTY STATE									
Cremation									
3-28-1983									
Delmarva									
Lewes, Sussex, Delaware									
24. FUNERAL DIRECTOR									
25a. DATE REC'D. BY REGISTRAR									
25b. REGISTRAR'S SIGNATURE									
Newnam Funeral Home									
Easton, Md.									
MAR 29 1983									



Handwritten text, possibly a signature or name, written in cursive script.

Handwritten text, possibly a date or short phrase, written in cursive script.

Handwritten text, possibly a number or small note, written in cursive script.

Handwritten text, possibly a signature or name, written in cursive script.

Susan Marsh - RC 2 304. Dr. Trever
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 1/75
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified in person.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 3 0 8 5 1 6			
1- FOR STATE REGISTRAR										REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Susan Elizabeth Marsh					2a. DATE OF DEATH MARCH 10 1983					2b. HOUR 2:30a _M			
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH NOV. 25 1892			6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Talbot MD						
10 CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Center-The Pines					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.					13b. CITY OR TOWN Talbot		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 412 Arbor Place 21601				
14 FATHER'S NAME FIRST MIDDLE LAST Philip J. Blann					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Elizabeth Beckwith								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-74-5399		17 INFORMANT ADDRESS Margaret E. Roe Easton, Md.								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Basilar artery thrombosis</u> <u>4330</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH } <u>Uncertain</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>none</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) (this hospital) attended the deceased from <u>8-24</u> , 19 <u>70</u> , to <u>3-10</u> , 19 <u>83</u> , that (1) (we) last saw the deceased alive on <u>3-4</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Robert W. Trever, M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3-11-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Trever, M.D.					22e. ADDRESS RD 3 Box 297 Easton, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-12-83		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot Md					
24. FUNERAL DIRECTOR NAME Newnam Funeral Home					ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR MAR 15 1983						
					25b. REGISTRAR'S SIGNATURE John J. Canick								

MAR 15 1983
Faint, illegible handwritten text

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 0 8 5 1 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JEROME R MARSHALL			2a. DATE OF DEATH MONTH 3 DAY 9 YEAR 83			2b. HOUR 6³⁰ P. M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH JULY DAY 20 YEAR 1891		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUILDER	
12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		13a. STREET ADDRESS 3 SWAN HAVEN 21601					
13b. STATE MARYLAND		13c. CITY OR TOWN TALBOT		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3 SWAN HAVEN 21601	
14. FATHER'S NAME FIRST E. CLARK MIDDLE MARSHALL LAST				15. MOTHER'S MAIDEN NAME FIRST MARY LAST SEARS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-16-3706		17. INFORMANT ADDRESS 3 SWAN HAVEN EASTON, Md. MILDRED F. LANGRELL			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) G.I. Bleeding 5314 DUE TO, OR AS A CONSEQUENCE OF (b) Gastric Ulcer DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute ?	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Constrictive Heart Failure - Acute

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/9/83 to 3/9/83 , that (I) (we) last saw the deceased alive on 3/9/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (that) did not view the body after death.							
22b. SIGNATURE P. G. Rhodes		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/10/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. GREGG RHODES MD				22e. ADDRESS 400 Dutchmans Ln, Easton, Md 21601			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MARCH 12, 1983		23c. NAME OF CEMETERY OR CREMATORY OLIVET CEMETERY		23d. LOCATION CITY OR TOWN ST. MICHAELS COUNTY TALBOT STATE Md.	
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24. FUNERAL DIRECTOR NAME James E. Ziemer ADDRESS St Michaels Rd		25a. DATE REC'D. BY REGISTRAR MAR 16 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	
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RECEIVED

10-11-1944

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10-11-1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST ADA MAE NEAVITT			MONTH DAY YEAR MARCH 3, 1983			9:29 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
FEMALE	WHITE	MONTH DAY YEAR JUNE 6, 1892	90 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND	U.S.A.		TALBOT MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
EASTON 21.601	MERIDAN IN THE PINES		HOUSEWIFE			HOME		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS				
MARYLAND	TALBOT	ST. MICHAELS	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	S. TALBOT ST. 21663				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST JOHN HARRISON		FIRST MIDDLE LAST MARY C. HARRISON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT				
NO		----		215-20-1116 MAE STEILKIE BOZMAN, MARYLAND 21612				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 4292 DUE TO: CHAIN OF CONSEQUENCE OF <i>Cerebrovascular Cardiovascular year</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last DUE TO: OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE PERIOD BETWEEN ONSET AND DEATH: <i>1 year</i>								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>10-9-1970</i> to <i>3-3-83</i> , that (I) <i>was</i> last saw the deceased alive on <i>3-3-83</i> , and that in my <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (If (we) (do) (do not) view the body after death)								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
<i>R. Lane Wroth, M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			3-4-83		
22d. PHYSICIAN'S NAME (Type or Print)			22e. ADDRESS					
R. LANE WROTH M.D.			ST. MICHAELS, MARYLAND 21663					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
BURIAL		MARCH 6, 1983		BOZMAN, CEMETERY		TALBOT MD		
24. FUNERAL DIRECTOR				25. DATE REC'D. BY REGISTRAR				
<i>James E. Leonard Jr. Michael Steilkie</i>				MAR 9 1983 <i>John G. Smith</i>				

BP



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 0 8 5 1 9	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Walter B. Palmer, JR.					2a. DATE OF DEATH MONTH DAY YEAR 3-23-83			2b. HOUR 12:54 A			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 24, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.					
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital at Easton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN Caroline		13c. CITY OR TOWN Denton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 209 South Fifth Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Walter B. Palmer, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Rebecca Coates						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II		16b. SOCIAL SECURITY NO. 222145312		17. INFORMANT ADDRESS Mrs. Genevieve Palmer, Denton, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF, (b) CORONARY ATHEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF, (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE chronic											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) HYPERTENSION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3/22/83 to 3/23/83 , that (I) (we) last saw the deceased alive on 3/22/83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not view the body after death.											
22b. SIGNATURE Christian E. Jensen MD					DEGREE MO		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/24/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Christian E. Jensen, M. D.					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/26/83		23c. NAME OF CEMETERY OR CREMATORY Denton Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Denton Caroline Md.					
24. FUNERAL DIRECTOR NAME Moore Funeral Home 1246 2nd St. Denton, Md.					25a. DATE REC'D. BY REGISTRAR MAR 29 1983						
					25b. REGISTRAR'S SIGNATURE John J. Canfield						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 0 8 5 2 0			
1. FOR STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR		
Annabelle			PARKS			3-21-83			4:06 AM				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS	
female			white			Sept. 15, 1923			59 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Indiana IN.			U.S.A.						TALBOT MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Easton			Memorial Hospital			housewife							
13a. STATE			13b. COUNTY			13c. INSIDE CITY LIMITS?			13d. STREET ADDRESS				
Md.			Q.A. Co.			Grasonville YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Rt#1 Box # 505			21638	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
FIRST MIDDLE LAST			FIRST MIDDLE LAST										
Roy C. Bevelhimer			Esther Frederich										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS				
no			316-14-8523			Ephraim Parks, Jr.			21638 Md. Rt#1 Box 505, Grasonville				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) 1749 Carcinoma toxis													
DUE TO, OR AS A CONSEQUENCE OF: (b) Metastatic carcinoma, left breast 3 years													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF: (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
			P.M. 19										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK													
22a. I certify that (I) (this hospital) attended the deceased from 2-21-83 to 3-21-83, that (I) (we) last saw the deceased alive on 3-20-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE						DEGREE		22c. DATE SIGNED					
Jonathan Hummel, M.D.						M.D.		3/21/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS							
Jonathan Hummel, M.D.						Easton, Md. 21601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial			3-23-83		Woodlawn Cemetery			Easton, Talbot Co. Md.					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Helfenbein-Hubbard Rt#1 Box # 66-B Chester, Md.						MAR 28 1983		John J. Carver					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 08521			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT C. POOLE				2b. HOUR 9⁰⁵ A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 18, 1925		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 58	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT Co. MD.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EASTON MEMORIAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Photo Specialist		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				Zip Code - 21619			
13a. STATE Maryland		13b. COUNTY Queen Annes		13c. CITY OR TOWN Chester		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Milton E. Poole				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mina E. Mullinix			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-Navy		16b. SOCIAL SECURITY NO. W.W.II 578-24-8815		17. INFORMANT ADDRESS Mr. Alan E. Poole 15814 Wayne Ave. Laurel, Md. 20707			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BLADDER 1889 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 28 JAN , 19 83 , to 6 MAR , 19 83 , that (I) (we) last saw the deceased alive on 6 MAR , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Stephen P. Comylan				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-6-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Comylan, M.D.				22e. ADDRESS Easton, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 9, 1983		23c. NAME OF CEMETERY OR CREMATORY George Wash. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville P.G. Maryland	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Md.				25a. DATE REC'D. BY REGISTRAR MAR 10 1983			
				25b. REGISTRAR'S SIGNATURE Joan J. Comylan			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 08522	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Thurmon L Potter</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>3-5-83</i>			2b. HOUR M			
3. SEX <i>Male</i>		4. RACE <i>Blk</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8 25 12</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>70</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.					
10. CITY OR TOWN OF DEATH <i>St Michaels</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>229 North Street</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Saboteur</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>md</i>		13b. CITY OR TOWN <i>Talbot</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>229 North St.</i>		13d. CITY OR TOWN <i>St Michaels</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>unk</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>unk</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>215-16-8548</i>		17. INFORMANT ADDRESS <i>Kim Roberts</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Severe Chronic Obstructive Lung Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>years</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Occult Malignancy RSH.D</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>19 79</i> , to <i>19 83</i> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <i>2/14</i> <i>19 83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.											
22b. SIGNATURE <i>P. Gregg Rhodes</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>3/11/83</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>P. GREGG RHODES MD</i>			22e. ADDRESS <i>400 Dutchman's Lane, Easton, Md, 21601</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>3/11/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Thomas Corn</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>St Michaels TA md</i>			
24. FUNERAL DIRECTOR NAME <i>Leopold A. DeLuca</i>						ADDRESS <i>Easton md</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 21 1983</i>			
						25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 0 8 5 2 3	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			2b. HOUR			
FIRST MIDDLE LAST Bertha Rebstock					MONTH DAY YEAR 3. 12 83			4:35 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR			
Female		White		MONTH DAY YEAR Oct. 5, 1907		75 YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Stuttgart, Germany		U.S.A.				Tallbot MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Easton		Memorial Hospital				Housewife		Own Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Caroline		Federalsburg				21632 Box 389A - Laurel Grove Road			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST Karl Feinauer					FIRST MIDDLE LAST Luise Glaser						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No					218-20-7770		Maryland 21632 William F. Rebstock, Box 389A, Federalsburg,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Basilar artery thrombosis											
4330 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Arteriosclerosis											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
Metastatic lung carcinoma											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2-28, 1983, to 3-12, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE					DEGREE			22c. DATE SIGNED			
Robert W. Trever, M.D.					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			3-13-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
Robert W. Trever, M.D.					RD 3 Box 297 Easton, Md. 21601						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
Burial			Mar. 16, 1983		Hillcrest Cemetery		Federalsburg, Caroline, Md.				
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
NAME ADDRESS Frampton Hawkins Funeral Home Federalsburg, Md.					MAR 17 1983		John J. Conner				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP _____

DHMH - 16 50M 4/82
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 0 8 5 2 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Ruth Sullivan Reed</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3-11-83</i>			2b. HOUR <i>11:30</i> M			
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>April 21, 1894</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.			
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital at Easton</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Caroline</i>		13c. CITY OR TOWN <i>Denton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>Hobbs Road</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Alonzo Griffith</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mamie Adams</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>213103877</i>		17. INFORMANT ADDRESS <i>Mrs. Frances Reinhart, Denton, Md.</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4360

IMMEDIATE CAUSE (a)

Massive CVA

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)

Coronary Artery Disease - atherosclerotic, Peripheral Vascular Disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>3-8</i> , 19 <i>83</i> , to <i>3-11</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>3-11</i> , 19 <i>83</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Terry Detrich M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Terry Detrich, M.D.</i>				22e. ADDRESS <i>Easton, Md. 21601</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/14/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Denton Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Denton Caroline Md.</i>	
24. FUNERAL DIRECTOR NAME <i>M. O. REYNOLDS</i>						25a. DATE REC'D. BY REGISTRAR (b) REGISTRAR'S SIGNATURE <i>MAR 21 1983 John J. Gault</i>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of place.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]

1. [Illegible]
2. [Illegible]
3. [Illegible]
4. [Illegible]
5. [Illegible]
6. [Illegible]
7. [Illegible]
8. [Illegible]
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39. [Illegible]
40. [Illegible]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8308525

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET F. REPPEN			2a. DATE OF DEATH MONTH DAY YEAR 3 16 83			2b. HOUR 3:00 PM	
3. SEX female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 12, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary	
12b. KIND OF BUSINESS OR INDUSTRY government		21601					
13a. STATE Maryland			13b. CITY OR TOWN Talbot		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Edward Finegan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary McElroy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) no			16b. SOCIAL SECURITY NO. 180-18-6185		17. INFORMANT ADDRESS Dorothy M. Wilbur Tilghman, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Respiratory Failure 4960 DUE TO, OR AS A CONSEQUENCE OF (b) Severe Chronic Obstructive Lung DUE TO, OR AS A CONSEQUENCE OF (c) Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cor Pulmonale							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/16/83 to 3/16/83 , that (I) (we) lost saw the deceased alive on 3/16/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE P. G. Rhodes				DEGREE MD		22c. DATE SIGNED 3/17/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. G. Rhodes				22e. ADDRESS 400 Dutchmans Lane, Easton, Md.			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 3-19-1983		23c. NAME OF CEMETERY OR CREMATORY Tilghman Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE Tilghman, Talbot, Md.	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR MAR 24 1983	

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MEDICAL CERTIFICATION

99

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MARKS APRIL 1 - 1.0000

THE

PHYSICAL

DISORDER

Can be treated

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the retained by the hospital or attending physician. Pages 1 and 2 should be removed carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 0 8 5 2 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PIETERNELLA H. (a.k.a. NELLIE) KOOS				2a. DATE OF DEATH MONTH DAY YEAR 3-21-83		2b. HOUR 2:15 P.M.	
3. SEX female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 31, 1890		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 92	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Netherlands		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital at Easton		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) secretary		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Talbot		13c. CITY OR TOWN Easton	
14. FATHER'S NAME FIRST MIDDLE LAST Cornelius L. Plansoen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhelmina Verneulen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 137-09-3049		17. INFORMANT Alice B. Nily		ADDRESS Easton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>abdominal aneurysm & rupture</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>years</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>long standing iron deficiency anemia, ASVD & chronic HT</u>							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/21/83</u> to <u>3/21/83</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>3/21/83</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)							
22b. SIGNATURE <u>Robert T. Dawkins Jr.</u> M.D.				DEGREE M.D.		22c. DATE SIGNED 3/23/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert T. Dawkins Jr. M.D.				22e. ADDRESS Route 3, Box 127 Easton Maryland 21601			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 3-25-1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Paterson, Passaic, N.J.	
24. FUNERAL DIRECTOR Newram Funeral Home				25a. DATE REC'D. BY REGISTRAR MAR 28 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Connelley</u>	

Page 10-10-3

10/10/3

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 0 8 5 2 7 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles S. Salisbury Rose				2a. DATE OF DEATH MONTH DAY YEAR March 13, 1983				2b. HOUR 8:50 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 7, 1986		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian - The Pines				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter (retired)		12b. KIND OF BUSINESS OR INDUSTRY Housing	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Queen Anne's		13c. CITY OR TOWN Wye Mills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Willard Salisbury Rose				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Mae Elliott					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 218-09-1314		17. INFORMANT Daughter		ADDRESS P.O. Box 237 Mrs. Dorothy R. Tarbuton, Queenstown, Md. 21658			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY 4292 IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from NOV 82 to MAR 83, that (I) (we) lost saw the deceased alive on MAR 16 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M.D. Crowley				DEGREE M.D.				22c. DATE SIGNED 3.14.83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.D. CROWLEY				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 16, 1983		23c. NAME OF CEMETERY OR CREMATORY Chesterfield		23d. LOCATION CITY OR TOWN COUNTY STATE Centreville, Q.A.Co., Md.			
24. FUNERAL DIRECTOR NAME James H. Barton, Jr., Centreville, Md. 21617				25a. DATE REC'D. BY REGISTRAR MAR 21 1983		25b. REGISTRAR'S SIGNATURE John J. Carver			

BP

1. Name of the person or organization to whom the letter is addressed.
 2. Address of the person or organization to whom the letter is addressed.
 3. City, State, and Zip Code of the person or organization to whom the letter is addressed.
 4. Date of the letter.
 5. Salutation (e.g., Dear Sir, Dear Madam, Dear Mr. Smith).
 6. Body of the letter (the main text).
 7. Closing (e.g., Sincerely, Very truly yours, Respectfully).
 8. Signature of the person sending the letter.
 9. Name and Title of the person sending the letter.
 10. Address of the person sending the letter.

MAR 21 1983
 John B. Smith

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 0 8 5 2 8

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WALTER Y. Saulsbury			2a. DATE OF DEATH MONTH DAY YEAR March 26, 1983		2b. HOUR 4 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR FEB. 26 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.	
10. CITY OR TOWN OF DEATH EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY Talbot	13c. CITY OR TOWN Trappe	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS R.D. 1, Box 96 A 21673
14. FATHER'S NAME FIRST MIDDLE LAST Richard W. Saulsbury			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elenora Watts		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-36-1081		17. INFORMANT ADDRESS R.D. 2, Box 112 Clara S. Outten Trappe, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **4275**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

Cardiorespiratory Arrest

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3-25-83 P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21i. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-25-83 to 3-26-83 , that (I) (we) last saw the deceased alive on 3-25-83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Thomas W. Fauntleroy, M.D.		DEGREE M.D.	22c. DATE SIGNED 3-26-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas W. Fauntleroy, M.D.		22e. ADDRESS Easton, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-28-83	23c. NAME OF CEMETERY OR CREMATORY Spring Hill	23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot Md
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		25a. DATE REC'D. BY REGISTRAR MAR 29 1983	
ADDRESS Easton, Md.		25b. REGISTRAR'S SIGNATURE John J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF MEDICAL SERVICE
WASHINGTON, D. C.

March 20, 1918

John L. S. M. D.

Walter

John L.

Memorandum

John L.

10-1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 0 8 5 2 9

STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) HERBERT E. SCHELLS				2a. DATE OF DEATH MONTH DAY YEAR 3 20 83		2b. HOUR 7 40 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 18 1906		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Md.		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13e. STREET ADDRESS 1 Hyde Park 21601	
14. FATHER'S NAME FIRST MIDDLE LAST Frank H Schells				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie Plummer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 218-16-9977		17. INFORMANT ADDRESS Nellie V. Schells Easton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) A.S.H.D. — A.S.H.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Recent Aorto-Coronary Bypass — (Recent Aorto-Coronary Bypass)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/20 19 83 to 3/20 19 83 , that (I) (we) last saw the deceased alive on 3/20 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE Gregg Rhodes, M.D.				DEGREE M.D.		22c. DATE SIGNED 3/21/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregg Rhodes, M.D.				22e. ADDRESS 400 Dutchman's Lane, Easton, Md 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-23-83		23c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE St. Michaels Talbot Md	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR MAR 28 1983	
				25b. REGISTRAR'S SIGNATURE John J. Amiel			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



CHIEFMAN

2001 COLL

RECEIVED

EASTON MEMORIAL HOSPITAL

INVEST

Outstanding Account

A.S.A.D.

(Present Name - formerly [illegible])

1/15/57

and [illegible] of [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8308530			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST PEARL		MIDDLE Amelia		LAST SHIFLER		2a. DATE OF DEATH		MONTH 3	DAY 18	YEAR 83	2b. HOUR 8 ⁰⁵ A.M.
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH April 8 th YEAR 1892		6. AGE (IN YEARS LAST BIRTHDAY) 90		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mapleville, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD							
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EASTON MEMORIAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Funkstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 133 Stouffer Ave. 21734			
14. FATHER'S NAME FIRST David MIDDLE H. LAST Stouffer				15. MOTHER'S MAIDEN NAME FIRST Maria MIDDLE Elizabeth LAST Rohrer				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					
16b. SOCIAL SECURITY NO. 220-34-1109				17. INFORMANT Mr. Steven Stouffer,				ADDRESS 133 Stouffer Ave. Funkstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.H.F.</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart Dis.</u> conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Alzheimer's Disease, Renal Failure years</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/23/83</u> to <u>3/18/83</u> , that (I) (we) last saw the deceased alive on <u>3/17/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>[Signature]</u>		22c. DATE SIGNED 3/18/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. GREGG RHODES MD		22e. ADDRESS 400 Dutchman's Lane, Easton, Md 21601		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-21-83		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION CITY OR TOWN Boonsboro, Wash. Co., Md.		23e. COUNTY		23f. STATE			
24. FUNERAL DIRECTOR NAME <u>J. E. Boulain</u>		24b. ADDRESS <u>Greenbelt Md 21639</u>		25a. DATE REC'D. BY REGISTRAR MAR 22 1983		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 08531			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carl E Shufelt				2b. DATE OF DEATH MONTH DAY YEAR 3-17-83			
3. SEX Male				2b. HOUR 28 PM			
4. RACE White				5. DATE OF BIRTH MONTH DAY YEAR 1 27 1901			
6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.				7. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH Easton				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber				12b. KIND OF BUSINESS OR INDUSTRY Barber Shop			
13a. STATE Maryland				13b. COUNTY Caroline			
13c. CITY OR TOWN Federalsburg				13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS 324 North Main Street				13f. ZIP CODE 21632			
14. FATHER'S NAME FIRST MIDDLE LAST Elmer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lura McMahan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 218-20-9671			
17. INFORMANT ADDRESS Mrs. Ted Fletcher Preston, Md. 21655				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4151 IMMEDIATE CAUSE (a) PROBABLE PULMONARY EMBOLISM			
DUE TO, OR AS A CONSEQUENCE OF (b)				DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 9							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 3/10		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/10/83, 19 83, to 3/17/83, 19 83, that (I) (we) last saw the deceased alive on 3/17/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE [Signature]		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/10/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]		22e. ADDRESS [Signature]					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-21-83		23c. NAME OF CEMETERY OR CREMATORY Unity Washington		23d. LOCATION CITY OR TOWN COUNTY STATE Hurlock Dorchester Md.	
24. FUNERAL DIRECTOR [Signature]		ADDRESS [Signature]		25a. DATE REC'D. BY REGISTRAR MAR 28 1983		25b. REGISTRAR'S SIGNATURE [Signature]	

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Eastern Maryland Hospital

314 North Main Street

215-22-3571 Mrs. Ted Placener

U.S. Department of Health

Washington, D.C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08532	
1. DECEASED NAME (TYPE OR PRINT) Kenneth H Swann										2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 3 DAY 3 YEAR 1983 HOUR 10:00 AM	
1. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH JAN. DAY 8 YEAR 1913	6. AGE 19 YEARS 70 YRS. (LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS 	8. IF UNDER 24 HRS. HOURS MIN. 	3c. DATE PRONOUNCED DEAD 3-3 19 83		3d. HOUR 10:00 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.					
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital at Easton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY			
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. CITY OR TOWN Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.D. 3, Box 782 21601			
14. FATHER'S NAME FIRST James MIDDLE Elmer LAST Swann					15. MOTHER'S MAIDEN NAME FIRST Minnie MIDDLE Amelia LAST Taylor						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-20-7959		17. INFORMANT Rebecca S. Swann		ADDRESS Easton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Primary Heart Res DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE R. Lane Wroth, M.D.				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER DATE SIGNED 3-4-83			
EXAMINER'S NAME (TYPE OR PRINT) R. Lane Wroth, M.D.				ADDRESS St. Michaels, Md. 21663							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3-7-83		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot Md			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home ADDRESS Easton, Md.						25a. DATE REC'D. BY REGISTRAR MAR 8 1983		25b. REGISTRAR'S SIGNATURE John J. Cawley			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR Items 4 thru 13 Phone 8308533 STATE REGISTRAR 4-13-83 cn									
1. DECEASED NAME (TYPE OR PRINT) Baby Boy Taylor						2a. DATE OF DEATH MONTH DAY YEAR Mar 28 83		2b. HOUR 2:45 AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3-28-83		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 15		7b. HOUR 15	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Talbot		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md		13c. CITY OR TOWN Talbot		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2 Box 194		13f. ZIP CODE 21601	
14. FATHER'S NAME FIRST MIDDLE LAST James Albert Taylor				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vera Ann Meredith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Curiae arrest 7651 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respiratory arrest (c) Prematurity									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Premature labor									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard H. Fritz				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/28/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard H Fritz MD				22e. ADDRESS 605 Dutchman's La Easton Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		23d. LOCATION CITY OR TOWN COUNTY STATE Easton, Md.			
24. FUNERAL DIRECTOR NAME (Incenerated)				ADDRESS		25a. DATE REC'D. BY REGISTRAR APR 7 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

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STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 3 0 8 5 3 4

 1- FOR
 STATE
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mercedes C Thuman			2a. DATE OF DEATH MONTH DAY YEAR 8-29-83		2b. HOUR 10¹³ M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 8, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Queen Anne	13c. CITY OR TOWN Grasonville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Grimes			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Fritz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-28-9589		17. INFORMANT ADDRESS William Thuman, 500 Foster Knoll Dr, Joppatown, MD 21085	

 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:

 IMMEDIATE CAUSE (a) **Metastatic colon cancer**
1539

DUE TO, OR AS A CONSEQUENCE OF

 Conditions, if any, which
 gave rise to immediate
 cause (a), stating the
 underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(c)

 APPROXIMATE INTERVAL
 BETWEEN ONSET AND DEATH
11 mo

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Apr 19 82 to 29 Mar 19 83 , that (I) (we) last saw the deceased alive on 29 Mar 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE Stephen P. Carney	DEGREE M.D.		22c. DATE SIGNED 3-30-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.		22e. ADDRESS Easton, Md. 21601	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/29/83	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.		25. DATE REC'D. BY REGISTRAR APR 4 1983	
ADDRESS Funeral Home Baltimore, Md.		REGISTRAR'S SIGNATURE J. Carney	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR REGISTRAR					8 3 0 8 5 3 5				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
ISAIAH TILGHMAN JR.					3 2 83				
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH Aug. 24, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		2b. HOUR 8:15 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mem Hospital Easton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY Queen Anne's		13c. CITY OR TOWN QUEENSTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST JAMES TILGHMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY		13e. STREET ADDRESS R.F.D. #1 21658					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-32-2015		17. INFORMANT ADDRESS MRS. MARGIE T. Tilghman R.F.D. #1 QUEENSTOWN, MD. Box #328					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4659 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) LOWER RESPIRATORY TRACT INFECTION. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 HRS.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHRONIC RENAL FAILURE, SCHIZOPHRENIA-COMPENSATED.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from August 1979 to MAR 2 1983, that (I) (we) last saw the deceased alive on MAR 1 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.									
22b. SIGNATURE James Longmore				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3-3-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Longmore, M.D.				22e. ADDRESS Centreville, Md. 21617					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/5/1983		23c. NAME OF CEMETERY OR CREMATORY M-F BENEFICIAL		23d. LOCATION CITY OR TOWN COUNTY STATE CENTREVILLE TALBOT MD.			
24. FUNERAL DIRECTOR NAME Kenneth W. Waley				ADDRESS Chesapeake		25a. DATE REC'D. BY REGISTRAR MAR 11 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

Controlled by the Government

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W. L. D. D. D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8308536						
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES Stanley WALKER					3 8 83					10 ⁵⁰ P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		September 3, 1897		85 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				TALBOT MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
EASTON		MEMORIAL HOSPITAL						Merchant (retired)		General Store	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
13a. STATE 13b. CITY					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Brown's Corner 21617				
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
James Wesley Walker					Rosa Ella Barnes						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No					212-16-7300		Mrs. Marcy F. Collier, Centreville, Md. 21617				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4039 IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Uncertain</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <u>None</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>											
22a. I certify that (i) (this hospital) attended the deceased from <u>March 7</u> , 19 <u>83</u> , to <u>March 8</u> , 19 <u>83</u> , that (ii) (we) last saw the deceased alive on <u>March 8</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (h) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Robert W. Trever, M.D.										3-9-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Robert W. Trever, M.D.						RD 3 Box 297 Easton, Md. 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				Mar. 11, 1983		Chesterfield		Centreville, Q.A. Co., Md.			
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James H. Barton, Jr., Centreville, Md. 21617						MAR 15 1983		John J. Connel			

[illegible]



MAR 2 1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 0 8 5 3 8 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) CHARLES O WRIGHT						2a. DATE OF DEATH MONTH DAY YEAR March 26, 1983			2b. HOUR 10:02 AM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 3, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.					
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EASTON MEMORIAL Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Electric			
13a. STATE Maryland						13b. COUNTY Caroline		13c. CITY OR TOWN Denton		13d. STREET ADDRESS Campground Road	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Wright						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida May Roe					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219077375		17. INFORMANT ADDRESS Mrs. Catherine Wright, Denton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4254 IMMEDIATE CAUSE (a) Intestinal fibrosclerosis DUE TO, OR AS A CONSEQUENCE OF (b) Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) monkeys										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 2-22 , 19 83 , to 3-26 , 19 83 , that (we) last saw the deceased alive on 3-26 , 19 83 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did) (did not) view the body after death.											
22b. SIGNATURE Thomas W. Fauntleroy, Jr. M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-26-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas W. Fauntleroy, Jr. M.D.						22e. ADDRESS Denton, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/30/83		23c. NAME OF CEMETERY OR CREMATORY Denton Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Denton Caroline Maryland			
24. FUNERAL DIRECTOR NAME Kindolph P. Moore						ADDRESS Denton, Md.		25a. DATE REC'D. BY REGISTRAR MAR 29 1983		REGISTRAR'S SIGNATURE John J. Carver	

BP

